QBE Personal Accident / Illness Claim

QBE Pacific Islands

A. Notes

1. It is most important that all questions are answered. If not applicable, write "n/a".
2. The issue of this claim form is not an admission of liability by QBE.
3. If there is insufficient space or further comment on any area is considered necessary, please use additional pages.
4. Any amounts further marked as * are in the currency of the country in which the policy has been issued.
5. Markets

Please use the checklist below to indicate the operation in the QBE Pacific Islands region to which you will be submitting your claim.

MARKET	BUSINESS NAME	PLEASE TICK
Fiji	QBE Insurance (Fiji) Limited	
Papua New Guinea	QBE Insurance (PNG) Limited	
Solomon Islands	QBE Insurance (International) Pty Limited	
Vanuatu	QBE Insurance (Vanuatu) Limited	

Note: For any other markets please contact the local QBE office.

6. Jurisdiction

The content and use of this form or any agreement entered into pursuant to this form or any dealing in relation to or arising from this form are governed by:
a) the laws of the country at the QBE office which issues the policy/ies upon which this present claim is made; unless
b) the policy/ies refer to the laws of a different country applying, in which case the laws of that country,
and in relation to those matters, the parties submit to the exclusive jurisdiction of the courts of that country.
For those policies governed by the laws of the Republic of Vanuatu, the validity, interpretation and effect and the rights and obligations of the parties to such policies shall be governed exclusively by English law as applicable within Vanuatu immediately before 30 July 1980 and shall be exclusively justiciable before the Supreme Court of Vanuatu.

B. Insured details

Name of insured

Address

Private tel. no | **Business tel. no** | **Mobile tel. no**

Fax no | **email**

Occupation | **Policy no**

Name of affected party | **Age**

Address

Tel. no | **Mobile tel no**

Have you ever previously met with an accident? If "Yes", please give full details below. ☐ Yes ☐ No

Have you ever previously suffered from any illness? If "Yes", please give full details below. ☐ Yes ☐ No

Date	Nature of accident/extent of injuries and/or illness	Duration of disablement

Have you ever previously claimed under a personal accident or illness policy? ☐ Yes ☐ No

If "Yes", please give particulars including name(s) of insurer(s).

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Are you insured against accident or illness with any other company? ☐ Yes ☐ No

If "Yes", please give full details.

Have you received or are you entitled to receive benefits under any workers' compensation act in consequence of this accident? If "Yes", please give full details. ☐ Yes ☐ No

Have you engaged in or attended to your business in any way since this accident occurred? ☐ Yes ☐ No

If "Yes", please give full details.

Are you able to engage in or attend to your business in any way? ☐ Yes ☐ No

a. If "Yes", to what extent?

b. If "No", when do you anticipate that you will be able to engage in or attend to your business in any way?

Are you confined to your bed? ☐ Yes ☐ No

Are you totally disabled? ☐ Yes ☐ No

State name and address of your medical attendant:

Date of last medical attendance

C. The accident / illness

1.If accident:

a. Date of accident Time

b. Place of accident

c. State exactly how the accident occurred?

d. State nature of injuries

e. State name(s) and address(es) of witness(es) to accident:

2.If illness:

a. Nature of illness

b. How long?

c. Please state how long you have been:

i) confined to house: from / / to / / ii) able to get outdoors: from / / to / /

d. Please state how long you have been:

i) totally disabled: from / / to / / ii) partially disabled: from / / to / /

D. Signature and declaration

I/we declare that:

1. The information and answers given above are correct to the best of my/our knowledge and belief.
2. I/we understand the claim may be refused or reduced if information is withheld.
3. I/we hauthorise QBE to disclose information contained herein to QBE's advisors, reinsurers and to other insurers. I/we authorise QBE to obtain from any other party information that is, in QBE's view relevant to this claim.

Signature of insured

Date

E. Medical certificate

To be completed by attending physician.

Are you still attending the insured person? ☐ Yes ☐ No

What are his/her present symptoms?

a. Totally disabled from / / **to** / / b. Partially disabled from / / **to** / /

If the insured person is still disabled, please state the probable date of their being able to resume a portion of their usual duties?

Date / /

How much longer is it probable the person's state of disability will continue? **days** **weeks** **years**

General remarks

I certify that to the best of my knowledge the foregoing statements are correct:

Name:

Address

Doctor's signature

Date

Fiji

QBE Insurance (Fiji) Limited

QBE Centre, 33 Victoria Parade
Suva
Tel: + 679 331 5455
Fax: + 679 330 0285
email: info.fiji@qbe.com
qbepacific.com

Papua New Guinea

QBE Insurance (PNG) Limited

QBE Building, Musgrave Street
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Tel: +675 321 2144
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qbepacific.com

Solomon Islands

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Vanuatu

QBE Insurance (Vanuatu) Limited

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